STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445469	A. BUILDING _____ B. WING	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY HALL NURSING HOME	301 WATAUGA AVE ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERIS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and In an environment that maintains or enhances each resident's dignity and respect In full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, observation, and interview, the facility failed to provide a privacy cover for a urinary drainage bag for 1 resident of 5 residents reviewed. The findings Included: Review of facility policy, Catheter Care, revised 7/14 revealed "...the drainage bag is to stored In a privacy cover..." Medical record review revealed Resident #6 was admitted on 3/4/15 with diagnoses including Altered Mental Status, Acute Respiratory Failure, Dementia, and a Pressure Ulcer. Observation on 6/15/15 at 7:30AM, on the C Wing Hallway outside the resident's room and visible from the hallway, revealed a urinary catheter collection bag with yellow colored urine attached to the bedframe without a privacy cover. Interview with the Director of Nursing on 6/15/15 at 7:45 AM, on the C Wing Hallway outside the resident's room, confirmed the facility failed to provide a privacy cover for the urinary catheter bag.		Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Ivy Hall Nursing Home of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Ivy Hall Nursing Home files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.	
F441	483.65 INFECTION CONTROL, PREVENT			

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE | TITLE | (X6)DATE

Judy C. Hall-Leach | ADMINISTRATOR | 7-1-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445469	A. BUILDING _____ B. WING	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY HALL NURSING HOME	301 WATAUGA AVE ELIZABETHTON, TN 37643

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F 441 SS=D	Continued From page 1 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as Isolation, should be applied to an individual resident; and (3) Maintains a record of Incidents and corrective actions related to infections. (b) Preventing Spread of Infection - (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F241	**F241** **Corrective Actions for Targeted Residents** A privacy cover was placed on Resident #6's urinary drainage bag by the DON immediately after being made aware of this issue on 6/15/15. **Identification of Other Residents with Potential to be Affected** Residents with urinary catheters in place have the potential to be affected by this practice. Facility residents with urinary catheters in place were checked by treatment nurse on 6/15/15 to privacy covers were in place over ensure drainage bags, per facility policy. All were in compliance. Education was initiated on 6/15/15 by DON for staff on duty regarding the need to ensure residents with urinary catheters in place have a privacy cover over the drainage bag, per facility policy. **Systematic Changes** Staff Meeting was conducted on 6/19/15 by DON for Nursing Staff regarding the need to ensure residents with a urinary catheter in place have a privacy cover over the drainage bag, per facility policy.	

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	445469	A. BUILDING _____ B. WING	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY HALL NURSING HOME	301 WATAUGA AVE ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation, and interview, the facility failed to utilize proper hand washing In between resident care for 3 residents on 1 hallway of 5 hallways observed and to prevent the spread of cross contamination with unlabeled hair combs and brushes for 2 of 7 shower rooms observed. The findings Included: Review of facility policy, Hand Washing, revised 9/08 revealed "...all employees shall utilize proper hand washing...before ...serving food...after contact with a resident.." Review of facility policy, Infection Control, revised 7/14 revealed "...proper hand washing...before and after providing Resident care, prior to eating..." Observation of Certified Nursing Assistant (CNA) #1 on 6/15/15 from 7:45 AM to 7:55 AM, on the C Wing Hallway, during breakfast service revealed tne following: CNA #1 entered a resident's room with a breakfast tray, cut up the food, touched the scrub top, touched the top of the hair, exited the room without washing the hands, entered another resident's room, picked up a walker and placed it in front of the resident, exited the room without washing the hands, retrieved another tray, poured coffee, placed a lid on the coffee cup, entered a third resident's room, retrieved the resident's eyeglasses from a drawer, placed the socks on the resident, and then cut the food on the breakfast tray without washing the hands.	F241	This in-service will be repeated on 7/3/15 by ADON to ensure Nursing Staff is educated. Newly-hired Nursing Staff will be educated during their orientation period by Administrative Staff regarding the need for a privacy cover to be in place over the drainage bag for residents utilizing a urinary catheter, per facility policy. **Monitoring** A monthly observation audit of privacy covers being in place over drainage bags for residents utilizing urinary catheters will be conducted by DON. The results of this audit will be presented by DON to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until desired threshold of 100% compliance is met for three consecutive months; then quarterly. The QAPI Committee consists of the Administrator, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	7/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445469	A. BUILDING _____ B. WING	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY HALL NURSING HOME	301 WATAUGA AVE ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 3 Interview with CNA #1 on 6/15/15 at 7:55 AM, on the C Wing Hallway confirmed the CNA had not completed hand washing In between contact with 3 residents and serving breakfast trays. Interview with the Director of Nursing on 6/15/15 at 8:00 AM, on the C Wing Hallway confirmed the facility staff failed to utilize proper hand washing in between resident care. Observation with CNA#3 on 6/15/15 at 10:35 AM, of the C Wing Female Shower Room revealed a basin containing 2 unlabeled hairbrushes with gray strands of hair. Observation with CNA #7 on 6/15/15 at 10:50 AM, in the B Wing Shower Room revealed a basin containing 3 unlabeled combs and 1 unlabeled hairbrush, all with gray strands of hair. Interview with the DON on 6/16/15 at 8:05 AM, at the B Wing nursing station confirmed the facility failed to follow infection control guidelines for cross contamination.	F 441	**F441-** **Corrective Actions for Targeted Residents** CNA #1 was counseled immediately on 6/15/15 by DON regarding the need for proper hand washing between resident-care, per facility policy. Unlabeled combs and hair brushes were removed from the Shower Rooms on Wing B and Wing C on 6/15/15 by CNA to prevent cross contamination. **Identification of Other Residents with Potential to be Affected** Current residents have the potential to be affected by this practice. Education regarding proper hand washing between resident-care and labeling of combs and hair brushes to prevent cross contamination was initiated for Nursing Staff by DON on 6/15/15. Staff was educated at this time to return all residents' personal items to their rooms after a shower. **Systematic Changes** Staff Meeting was conducted on 6/19/15 by DON for Nursing Staff regarding the need for proper hand washing between resident care, per facility policy. This in-service also addressed the need to label combs and hair brushes with residents' names to prevent cross contamination. Staff was educated to return all residents' personal items to their rooms after a shower.	
F 502	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain a laboratory test as ordered by the physician for 1 resident (#72) of 34 residents reviewed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445469	A. BUILDING _____ B. WING	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY HALL NURSING HOME	301 WATAUGA AVE ELIZABETHTON, TN 37643

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F 502	Continued From page 4 The findings included: Medical record review revealed Resident #72 was admitted to the facility on 12/23/14 with diagnoses including Depression, Dyspnea, Gastritis, Congestive Heart Failure, and Vascular Dementia. Medical record review of a Physician's Order dated 2/4/15 revealed "...BMP [Basic Metabolic Panel] in 2 wks [weeks]..." Medical record review revealed no documentation the BMP had been completed on 2/18/15. Interview with the Director of Nursing on 6/16/15 at 2:20 PM, in the conference room confirmed the BMP had not been obtained as ordered by the physician.	F441	**F441 Cont.** This in-service will be repeated on 7/3/15 by ADON to ensure Nursing Staff is educated. Newly-hired Nursing Staff will be educated by Administrative Staff during their orientation period regarding the need to perform proper hand washing between resident-care, per facility policy. Orientation education will also include the need to label combs and hair brushes with residents' names and to return all personal items to residents' rooms after a shower, to prevent cross contamination. **Monitoring** A monthly audit will be conducted by DON to observe Nursing Staff performing proper hand washing between resident-care, per facility policy. A monthly audit of facility shower rooms will be conducted by DON to ensure there are no unidentified personal items such as combs and hair brushes present, to prevent cross contamination. The results of these audits will be presented by DON to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until desired threshold of 100% has been met for three consecutive months; then quarterly. **Cont...**	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1003	A. BUILDING: _____ B. WING	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY HALL NURSING HOME	301 WATAUGA AVE ELIZABETHTON, TN 37643

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N000	Initial Comments A licensure survey was completed on June 15-17, 2015, at Ivy Hall Nursing Home. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	F441	**F441 Cont.** The QAPI Committee consists of the Administrator, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	7-3-15
		F502	**F502-** **Corrective Actions for Targeted Residents** A Basic Metabolic Panel was obtained for Resident #72 on 6/17/15. Results were reviewed by Resident #72's physician the same day with no new orders received. **Identification of Other Residents with Potential to be Affected** Residents receiving facility laboratory services have the potential to be affected by this practice. Upon investigation, Resident # 72's BMP was scheduled to be drawn on 2/18/15 as ordered. Facility failed to transcribe the BMP onto the laboratory requisition for the phlebotomist. Scheduled laboratory tests since 2/18/15 will be audited by DON to ensure all lab tests ordered by the physician were obtained. This will be completed by July 10, 2015.	

Division of Health Care Facilities/
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Judy L. Lockhart — ADMINISTRATOR — 7-1-15

by Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1003	A. BUILDING: _____ B. WING	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY HALL NURSING HOME	301 WATAUGA AVE ELIZABETHTON, TN 37643

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		F502	**F502 Cont.** **Systematic Changes** Staff Meeting was conducted on 6/19/15 by DON for Nursing Staff regarding the need to obtain all laboratory tests ordered by facility residents' physicians. This in-service was repeated on 6/29/15 by ADON to ensure Nursing Staff is educated. Newly-hired Nursing Staff will be educated by Administrative Staff during their orientation period regarding the need to obtain all laboratory tests ordered by the residents' physicians. Beginning 6/17/15 all laboratory orders are now reviewed by the MDS Nurse daily to ensure the test is scheduled correctly. MDS Nurse will then follow-up daily to verify that laboratory tests ordered for each day were obtained and results received by the facility. Facility has the capability to view and print laboratory results. RN Supervisor will conduct this process on the weekends. **Monitoring** MDS Nurse will conduct a monthly audit of laboratory tests being obtained as ordered by the physician. The results of this audit will be presented by MDS Nurse to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until desired threshold of 100% compliance is met for three consecutive months; then quarterly. **Cont...**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445469	A. BUILDING 01 - MAIN BUILDING A B. WING	06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY HALL NURSING HOME	301 WATAUGA AVE ELIZABETHTON, TN 37643

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		F502	**F502 Cont.** The QAPI Committee consists of the Administrator, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	7-10-15
K9999	FINAL OBSERVATIONS During the Life Safety portion of the initial certification survey conducted on June 16, 2015, no deficiencies were cited under 42 CFR PART 483, Requirements for Long Term Care for building 1.	K9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Judy C. McLeach — ADMINISTRATOR — 7-1-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.